Questions and Answers from the March 24, 2006 Webcast on Changes to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)

SAMHSA announced significant improvements to the agency's National Registry of Evidence-based Programs and Practices (NREPP). The new NREPP is the result of an extensive review of the procedures and criteria used in the previous system. Hundreds of stakeholders contributed to the process through responses to a Federal Register notice published on August 26, 2005.

NREPP will continue to provide detailed information on a range of programs and practices to prevent and/or treat mental and substance use disorders. At their option, all current NREPP programs (Model / Effective / Promising) will be re-reviewed and retained in the new NREPP.

SAMHSA expects the new NREPP to serve as a "decision support system" to help States, Tribes, community-based organizations and other interested stakeholders select programs and practices that meet their needs. A key part of this "system" will be the new searchable NREPP web site currently being developed and scheduled for launch in Fall 2006.

Included below are responses to questions received during the Webcast. SAMHSA was unable to adequately respond to a handful of questions that lacked sufficient context or detail. Questions and answers are organized by topic.

Inclusion of Interventions in NREPP

1. Has SAMHSA set the bar even higher for inclusion in NREPP?

The new NREPP takes a different approach and will include a much larger number of interventions than the old system. Unlike the old system that reviewed over 1,100 programs and included only 160, the new NREPP will include all programs and practices that are reviewed. In addition, the new system expands what is considered acceptable for inclusion in NREPP - such as some interventions that have been evaluated through a pretest/posttest study design.

2. Does the new NREPP exclude all interventions that don't use control groups?

No, the new NREPP system will include a wider range of study designs. This may include some pretest/post-test evaluations having no control groups.

3. Is SAMHSA is reducing the number of interventions on the new NREPP?

No, SAMHSA is not reducing the number of interventions on the new NREPP. In fact, more programs and practices will be included in NREPP. All programs currently on NREPP are assured of being included in the new system, as well as a range of new programs and practices. Over the next several years, SAMHSA anticipates a dramatic increase from the 160 interventions currently on NREPP.

4. Will the NREPP include older well-designed studies, such as the American Academy of Psychotherapists process and outcome studies done in the 1970s? I find that older studies are often overlooked because they are not included in electronic databases.

As a general rule, NREPP will not exclude older studies.

5. What types of interventions are specifically excluded from NREPP?

The specific prevention and treatment interventions that will be either included or excluded from NREPP reviews will depend upon the priorities established by each of SAMHSA's Centers. As indicated in the *Federal Register* Notice published March 14, 2006, (p.13136): "Designs at the lowest level of the evidence pyramid (i.e., observational, pilot, or case studies), while acceptable as evidence in some knowledge development contexts, will not be included in the NREPP system."

6. Will environmental interventions be reviewed and included in the new NREPP?

Yes, contingent upon the review priorities established each year by SAMHSA's three Centers, environmental interventions are very likely to be reviewed and included on the new NREPP. SAMHSA recognizes that these types of interventions are supported and favored by many States and communities, and therefore are important to review and include in NREPP.

7. If you include all programs and practices that are reviewed, does this mean some will not meet the required standards and that will be noted?

NREPP is not about identifying approved programs or required sets of standards. As indicated in the *Federal Register* Notice (p. 13135), "an array of information from multiple evidence dimensions will be provided to allow different user audiences to both identify (through Web-searchable means) and prioritize the factors that are important to them in assessing the relative strengths of different evidence-based approaches to prevention or treatment services."

8. It seems like you can get one or more zeroes and still get accepted. Is that true?

All interventions that are reviewed will be included on the new NREPP Web site.

9. Can an intervention make it on the registry with a good evidence score, but a low readiness score?

Yes.

10. Will NREPP include meta-analyses and expert panel reviews?

Perhaps, but only in rare cases (see response to Question 11, below).

11. I am confused about the value of the pyramid. Can you give an example of a program that would satisfy the top level (e.g., meta analysis)?

The evidence pyramid presented in the *Federal Register* Notice represents one model for classifying the quality of research evidence and was included as important background information. However, in practice, the types of evidence at the top level of the hierarchy--meta analyses and panel reviews -- rarely would be included in NREPP. Unlike meta analysis and panel reviews, NREPP evaluates specific applications of an intervention, not generic approaches or components of prevention /treatment interventions. Only if a meta analysis or review focused on a particular developer's version of the intervention, would it be included among studies evaluated by NREPP.

12. Will ALL designs that are single group pre-post-test and above, regardless of their score, be listed?

All interventions that are reviewed will be featured in NREPP regardless of scores or other information contained in the descriptive or rating dimensions. However, as noted in the section below, SAMHSA's Centers will identify the specific content areas, types of interventions, populations, or even types of research designs that will be prioritized for review. Therefore, it is possible that the Centers may elect to prioritize the review of interventions that have applied more rigorous research designs.

Priority Setting by SAMHSA Centers

13. How will SAMHSA set priorities for which interventions will be reviewed?

SAMHSA's three Centers will each establish priorities on an annual basis. Each Center is encouraged to seek input into this process from relevant stakeholder organizations. SAMHSA hopes to prioritize interventions for review that represent the interests and needs of stakeholders and reflect SAMHSA's matrix and grant priorities.

14. Does SAMHSA intend to include Restraint/Seclusion reduction programs on NREPP?

See response to Question 13, above.

15. What will be the criteria used by the Centers to determine priorities for programs/practices they want reviewed? Will this be a process that draws on stakeholder input?

See response to Question 13, above.

16. Do you anticipate any best practices for methamphetamine prevention?

See response to Question 13, above.

17. How do consumer operated services fit into the NREPP? For example, here in Alaska we have a variation on the SAMHSA Illness Management and Recovery model called

Illness Self Management and Recovery that is meant to be delivered by consumer operated programs?

See response to Question 13, above.

18. SAMHSA will set the priorities. Why not engage stakeholders through quarterly meetings or releasing notices for requests for comments in the Federal Register?

SAMHSA is currently exploring the most efficient mechanisms for obtaining stakeholder input on Center-level priorities. The process selected must balance SAMHSA's need for flexibility in responding to emerging challenges and service needs (i.e., at the local, state, and federal levels) with responsiveness to public and private stakeholder concerns.

19. NREPP will review mental health treatments, what does this include/exclude?

The specific mental health treatment interventions or approaches included in NREPP will depend upon the priorities established by SAMHSA's Center for Mental Health Services as noted above.

Emphasis on Behavioral Change Outcomes

20. Why is SAMHSA only considering interventions for NREPP that result in positive behavioral change?

SAMHSA will prioritize for NREPP review interventions that demonstrate positive changes in behavioral among individuals, communities, systems, and populations. However, in consultation with stakeholders, SAMHSA Centers may also consider including for NREPP review interventions that demonstrate other outcomes, such as long-term changes in attitudes or knowledge.

21. What is the NREPP definition of a "behavioral" outcome?

In general, a behavioral outcome refers to a measurable change in the observed behavior of an individual or group. However, in some research and evaluation contexts, the definition of what constitutes an "observed behavior" may be open to interpretation (e.g., participants' self-reports of past behaviors or future intentions to behave in a certain way). SAMHSA recognizes these conceptual and definitional complexities, and therefore each Center has flexibility in determining what may be considered a behavioral outcome.

Appropriate Uses of the New NREPP System

22. How will the new NREPP approve interventions?

The new NREPP is not about approving or disapproving interventions. Rather, it is a tool to assist stakeholders in making informed decisions about a variety of interventions that may or

may not address their specific needs. The new NREPP is a decision-support system that rates the strength of evidence for interventions.

23. Why is SAMHSA eliminating program labels - Model, Effective and Promising?

SAMHSA is eliminating these labels for several reasons. Increasingly, people and organizations were selecting interventions based on the label, and not on a careful analysis of whether the intervention would help them achieve their intended goals. Second, the labels were increasingly used to stifle innovation when purchasers would prohibit funding of interventions that didn't have a label and/or weren't on NREPP. In order to promote innovation and encourage thoughtful selection of interventions to better address state and community needs, SAMHSA is eliminating program labels.

24. How will the new NREPP system help professionals in the prevention field differentiate between those programs (formerly identified as model programs) that have sufficient scientific evidence demonstrating that the program can be used to effectively change behavioral outcomes from those so-called "scientifically defensible" programs (formerly identified as promising programs) that have not yet been shown to have sufficient rigor and/or consistently positive outcomes.

The "Strength of Evidence" rating dimension will assist stakeholders in making informed decisions about the quality and strength of the evidence base for any particular intervention. Higher scores on this dimension represent a stronger evidence base.

25. What will SAMHSA do to prevent agencies and payers from only funding interventions that are listed on NREPP?

Since SAMHSA has re-cast the new NREPP as a decision-support system, the information that will be provided on the new NREPP Web site will be designed to help stakeholders make informed decisions about what interventions best meet their specific needs. Armed with such information, SAMHSA believes that States and communities are in the best position to make determinations about which interventions to fund - whether these programs and practices are included on NREPP, some other registry, or not at all.

26. Will any program listed on NREPP be eligible for funding, or is there a total score cutoff?

As noted above, the new NREPP is not about identifying interventions that have been approved or disapproved for funding.

27. Since the new system is a decision-support system (DSS), will there be any 'level' criteria such that users of the DSS can distinguish more rigorous from less rigorous designs that tested the intervention we will be choosing to use?

A summary descriptor of the type of research/evaluation design will be included with the description of the intervention when it is posted on the new NREPP Web site. This descriptor

reflects generally accepted standards of research designs along a continuum of increasing rigor. Users should determine which research designs are acceptable to them as one part of making informed decisions about interventions.

28. Does the new NREPP grant any interim approvals / accreditations while long-term evaluations are being conducted?

Same response as to Question 22, above.

29. What is the benefit of registering a program in NREPP?

SAMHSA's vision is for the NREPP system to be used by a wide range of public and private individuals and organizations to make more informed decisions about evidence-based services. NREPP will enhance the public's knowledge about specific interventions, thereby increasing the potential that these interventions may be adopted more broadly.

Content / Functions of the New NREPP System

30. There seems to be fewer criteria in the new NREPP system as compared to the old; can you comment on this apparent reduction and the intent of the change?

The new NREPP "Strength of Evidence" review criteria have been carefully selected to assess important research dimensions that are equally applicable to treatment and prevention interventions at both the individual and community levels. In fact, a number of the original (16) criteria that were perceived as overly stringent or not applicable to some evaluation settings were eventually modified or removed from the system.

31. If a program reports effect sizes, how will NREPP standardize the scope/reach of those programs to better understand the context of the effect sizes?

It is not feasible at this time to include a precise estimate of program reach (i.e., representativeness of intervention participants) in the NREPP system. In order to calculate program reach with accuracy, population and study-specific numbers (or proportions) of participants falling into various demographic, ethno-cultural, or risk categories must be known. However, the NREPP descriptive dimension of 'Relevant Populations and Settings' will contain much information directly related to program reach and the representativeness of evaluation samples.

32. A major concern with the NREPP is that the SAMHSA system does not allow for incorporating "practice wisdom" or what is currently actually working from the direct practice standpoint. Will this flaw be addressed?

The *Federal Register* Notice describing the changes to NREPP notes the following (p.13135): "It is essential for end-users to understand that the descriptive information and ratings provided by NREPP are only useful within a much broader context that incorporates a wide range of

perspective – including clinical, consumer, administrative, fiscal, organizational, and policy – into decisions regarding the identification, selection, and successful implementation of evidence-based services." Contrary to discouraging the use of "practice wisdom," NREPP recognizes it as an essential component of decisions regarding the selection and provision of services.

33. I am an evaluator for many CBO's implementing EBPs. We believe that a forum should be created for thoughtful feedback to program developers regarding the true efficacy of their programs outside of the research environment. My question is – what process will be put into place to allow for this valuable feedback?

This is an interesting suggestion which SAMHSA may consider further as NREPP continues to evolve.

NREPP Reviewers and the Review Process

34. What are the minimum criteria for NREPP reviewers?

Reviewers for NREPP must possess the doctoral degree and demonstrate a strong background and understanding of current methods for evaluating prevention and treatment interventions. Also preferred are reviewers with direct experience in providing prevention and/or treatment services.

35. How will the NREPP contractor select reviewers?

Leadership within each of SAMHSA's three Centers will periodically review and approve panels of reviewers provided to them by the NREPP contractor. In general, reviewer panels will be comprised of individuals with expertise directly related to the types of interventions and approaches that have been prioritized by that Center.

36. Why will the identity of the reviewers be kept from the public?

The NREPP system will use anonymous reviewers, similar to the standard practice of most peer-reviewed journals.

37. Can programs nominate reviewers?

Any individual or organization can nominate reviewers for NREPP. The reviewer's name and curriculum vitae (*.pdf format) should be e-mailed to MANILA Consulting Group at: nrepp@manilaconsulting.net.

38. When can I submit a program or practice to NREPP?

NREPP accepts submissions at any time. Information concerning each submission is transmitted to the appropriate SAMHSA Center(s) and is considered for NREPP review based upon its consistency with identified priority areas and available contract resources.

39. What is the process by which programs/approaches will apply to be reviewed by NREPP? Will there be certain criteria to meet before being able to apply?

Application to NREPP usually consists of a series of steps facilitated by a staff member at MANILA Consulting Group called a Review Coordinator. Applicants usually start by submitting descriptive information about their intervention and include one or more outcome publications (or unpublished evaluations). The Review Coordinator then reviews these materials. If the intervention is appropriate for NREPP, the Review Coordinator will work with the applicant to compile the necessary documentation to support a full review.

40. Once complete materials are submitted for NREPP review how long do you anticipate the process taking before a final decision is made?

On average, NREPP anticipates a four to six week decision timeframe, after all materials are submitted by a program that has been approved by SAMHSA for review.

41. When will programs that want to be re-reviewed be provided the "specs" or criteria for the new review? And how long will the reviews take?

All programs listed on the current Web site (i.e., Model, Effective, and Promising categories) will be contacted by MANILA Consulting Group to determine their interest in having their program re-reviewed under the new system. These current programs are among the highest review priorities under the new NREPP system. SAMHSA will assess the pool of programs and practices interested in participating in re-reviews and establish a schedule for their completion during the coming year. The current SAMHSA Model Programs Web site will remain intact until all eligible programs have had the opportunity to be included in the new NREPP Web site.

42. Will written comments and detailed scoring be provided to programs that submit?

Yes, written comments and detailed scoring will be provided to all programs that are reviewed.

Additional Questions

43. Smaller providers are very worried that they won't have the resources available to conduct an evaluation of their programs or practices. What are SAMHSA's plans to provide funding to these providers, perhaps through its "service-to-science" grants? More broadly, what are plans to develop and fund the infrastructure necessary for all providers to implement and sustain evidence-based practices?

SAMHSA leadership is well aware of the need to address issues of resource allocation to promote both the development and adoption of evidence-based services. Each SAMHSA Center will consider appropriate ways of addressing these issues.

44. What are the definitions of "program," "policy" and "practice" in the context of the Strategic Prevention Framework and of NREPP?

SAMHSA's three Centers will provide guidance on the distinction between programs and practices in their respective areas.

45. What is SAMHSA's timeframe for launching the new NREPP system and new website?

SAMHSA anticipates initiating reviews using the new NREPP system in the Summer of 2006. The launch of the new NREPP Web site is tentatively scheduled for the Fall of 2006.

46. Can you define "long-term" changes? 6 months? 1 year? 2 years?

To our knowledge, this phrase is not used in any current description of the NREPP system; therefore we are unable to provide a definition.

47. Other sources, including some state authorities, are developing their own lists of effective practices. Will SAMHSA monitor these resources, and to what extent does inclusion on an alternate list make a practice acceptable to SAMHSA in the grant-making decision process?

SAMHSA's current practice is to monitor and identify resources in addition to NREPP (primarily national resources) that produce and/or disseminate evidence-based practice information. These resources are often listed by name in SAMHSA grant announcements, and web links to these organizations are commonly provided.

48. In order to read more about it, is the source for the evaluation settings (efficacy, effectiveness, dissemination) in the descriptive dimension the Flay et al. article in Prevention Science?

Two references for additional reading on this topic are:

National Institute on Mental Health, *Bridging Science and Service: A Report by the National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup* (http://www.nimh.nih.gov/publicat/nimhbridge.pdf).

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Network (FMHI Publication #231).